

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 530014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2026
NAME OF PROVIDER OR SUPPLIER CHEYENNE REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 214 EAST 23RD STREET CHEYENNE, WY 82001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 000	INITIAL COMMENTS	A 000			
A 142	<p>PATIENT RIGHTS: PRIVACY AND SAFETY CFR(s): 482.13(c)</p> <p>Patient Rights: Privacy and Safety</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, patient and staff interview, and policy review, the facility failed to ensure patient privacy for 1 of 8 sample patients (#5). The findings were:</p> <p>1.Review of the medical record for patient #5 showed diagnoses of left total knee arthroplasty, osteoarthritis of left knee, and chronic pain of left knee. On 8/28/25 the patient had outpatient surgery for a left total knee arthroplasty. The following concerns were identified:</p> <p>a. Interview with the patient on 2/12/26 at 9:58 AM revealed there were 3 nurses already in the room when the anesthesiologist walked in. The doctor was in the room, the EKG person came in the room, and an electronic medical record specialist was with the anesthesiologist. The patient stated the anesthesiologist lifted the gown and exposed his/her groin. The patient stated staff left the door wide open, s/he was embarrassed, felt a loss of dignity and felt it was unprofessional.</p> <p>b. Interview with physician #1 on 2/11/26 at 11:05 AM revealed while he was in the room the</p>	A 142			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 142	Continued From page 1 anesthesiologist did pull up the gown. The physician stated the anesthesiologist was in a rush and exposed the patient more than he should have. The physician stated he tried to cover the patient back up. The physician stated there was a nurse, the anesthesiologist, an electronic medical record specialist and himself in the room when it happened.	A 142			
A 154	2. Review of the policy "Patient's Rights and Responsibilities" last revised 6/6/24 showed "...A. Patient Rights...2. You the patient, have the right to receive care that supports your personal dignity, comfort, ..." USE OF RESTRAINT OR SECLUSION CFR(s): 482.13(e) Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to ensure restraints were discontinued at the earliest possible time for 1 of 3 patient records reviewed for restraints (#15). The findings were: 1. Review of the medical record for patient #15 showed an entry dated 1/15/26 and timed 8:30 PM by registered nurse (RN) #1 which showed	A 154			

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A 154	Continued From page 2 the initiation of soft wrist restraints for pulling at lines and tubes and removing equipment. The medical record showed the provider was at the bedside at 8:40 PM, and 9:05 PM. The 9:05 PM note showed "Provider has remained at bedside during patient aggressive behavior ripping at equipment and pulling at lines." Further review of the medical record showed the patient was discharged on 1/15/26 at 11:27 PM without any further documentation of the restraints, including when the restraints were disconnected. 2. Review of the physician orders failed to show an order for the restraints. 3. Interview with the ED director on 2/12/26 at 8:50 AM revealed the order for the restraints was not placed in the medical record by the physician. It would be the expectation for the physician to order the restraint for the nurse to perform the task. Further, he confirmed the discontinuation of the restraints was not in the notes. 4. Review of the policy "Restraints and/or Seclusion" last revised 12/14/22 showed "...Procedure, A. General Provisions: ...5. Restraint and/or seclusion are based on an individual order...6. The Practitioner primarily responsible for the patient's ongoing care, orders the use of restraint and/or seclusion in accordance with laws, regulations and organizational Medical Staff Bylaws."	A 154			
A 168	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(5) §§482.13(e)(5) - The use of restraint or seclusion must be in accordance with the order of a	A 168			

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A 168	<p>Continued From page 3</p> <p>physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and policy review the facility failed to ensure restraints were used in accordance with the order of a physician or other licenced practitioner for 1 of 3 patient records reviewed for restraints (#15). The findings were:</p> <ol style="list-style-type: none"> 1. Review of the medical record for patient #15 showed an entry dated 1/15/26 and timed 8:30 PM by registered nurse (RN) #1 which showed the initiation of soft wrist restraints for pulling at lines and tubes and removing equipment. The medical record showed the provider was at the bedside at 8:40 PM, and 9:05 PM. The 9:05 PM note showed "Provider has remained at bedside during patient aggressive behavior ripping at equipment and pulling at lines." Further review of the medical record showed the patient was discharged on 1/15/26 at 11:27 PM without any further documentation of the restraints, including when the restraints were disconnected. 2. Review of the physician orders failed to show an order for the restraints. 3. Interview with the ED director on 2/12/26 at 8:50 AM revealed the order for the restraints was not placed in the medical record by the physician. It would be the expectation for the physician to order the restraint for the nurse to perform the task. 4. Review of the policy "Restraints and/or 	A 168		

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